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Physicians' new letter

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Restructuring of the Medical Services Plan Operations

In response to the Ministry of Health Services recent reorganization, MSP has been restructured in order to improve efficiency within its core business areas. Key changes in MSP include a significant reduction in personnel, an increase in automated services, and the merging of several functions into a fewer number of program areas.

While MSP will continue to provide a comprehensive range of client services to physicians and medical office staff, reduced staffing and increased automation of services means changing the way services are provided. The following notes outline changes that may affect your business interactions with MSP.

MSP AND PHARMACARE OFFICE CLOSURES

The MSP offices in Burnaby and Victoria which have been open for in-person account transactions and premium payments were closed on March 28, 2002. This closure is possible because of increasing improvements in technology and MSP beneficiaries' expectations for the convenience that technology offers. In response, MSP introduced electronic transactions and telephone and on-line banking options, along with many refinements to internal practices for improved efficiencies in registration and premium billing. Pre-authorized payments will soon be introduced as an expanded feature of MSP client services.

Pharmacists working in the Vancouver-based Pharmacare office review and approve special authority applications and new drug submissions. Since the office does not provide direct service to the public, and conducts the majority of tasks by telephone, closure of this office later this year should not result in a discernable change in the way business is conducted.

(Continued page 2)

ELIMINATION OF MSP TOLL-FREE TELEPHONE NUMBERS

Client Services

Effective March 4, 2002, to contact a client service representative about registration or premiums, B.C. residents will need to call: 250 386-7171 (long distance outside of greater Victoria).

Telephone numbers to access automated/IVR services are:

250 382-8406	Victoria
604 683-7151	Vancouver
1 800 663-7100	other areas within B.C.

COVERAGE ENQUIRY

Effective May 1, 2002 coverage requests will be handled electronically and all automated services will be toll free. If you do need to speak to a client service representative you will be able to access them through the Victoria number only.

MSP recognizes that obtaining accurate patient information to submit a claim can sometimes be difficult. The following suggestions may be helpful.

Obtain patient information prior to a visit:

- When your patient calls for an appointment ask for their name and PHN (personal health number) exactly as it appears on their CareCard.
- Ask your patients to make sure they bring their CareCard with them to the appointment.
- Ask your patients if they have made changes to their name or coverage since their last visit.

Use the Practitioner Information Line (the old Coverage Information Line)

This Interactive Voice Response (IVR) service is able to provide coverage information any time of the day or night. On this line you are able to:

- Check date of patient's last eye examination
- Check patient's initials/surname
- Confirm coverage for date of service
- Confirm assignment of payment
- Verify responsibility for subsidy insured service
- Transfer to Info-by-Fax

Victoria	250 383-1226
Vancouver	604 669-6667
Toll-Free	1 800 742-6165

Please note: Requests for patient coverage information require a personal health number (PHN). If you do not have a personal health number you must submit a request on a coverage research form to fax number 250 952-3101.

Confirm Patient Information at the time of the visit

Teleplan's Immediate On Line Eligibility function provides coverage information while the patient is at your office. This service provides you with the ability to:

- Check coverage for up to 40 patients at one time
- Verify coverage for the current date plus the previous six months
- Learn if a patient is restricted to one physician
- Check when your patient had their last eye examination
- Check if subsidy insured service is paid by MSP or patient

Confirm Patient Coverage prior to the visit

Teleplan's Batch Eligibility function provides overnight verification of patient eligibility. There is no limit to the number of verification requests and the information is available the next morning. As your requests are processed overnight this allows you to submit your next day's or week's roster of patients.

Please note: IVR applications will no longer have staff access.

TRAVEL ASSISTANCE PROGRAM

Effective May 15, 2002, the Travel Assistance Program will be more fully automated. You will be able to call:

250 952-2657	Victoria
1 800 661-2668	other areas in within B.C.

Clients in most cases will no longer speak directly to a client service representative but will request TAP approval over the telephone using the IVR (interactive voice response) system. When calling the Travel Assistance Program, clients will need the completed "Request for Travel Assistance" form with the following information:

PART 1 – in this section of the form the following must be completed:

- Referring physician name
- Referring practitioner number
- Signature or office stamp
- Appointment date
- Escort medically required ticked yes or no and you must also complete
- Destination practitioner number or if that is not available tick Specialty Service

PART 2 – Hospital Use Only
Hospital name
Attending physician
Signature or office stamp
Discharge date

PART 3 – Completed by Patient
Name
Address
Postal Code
Telephone Number
Signature and Date

PART 4 – Confirmation Number
MSP Approval Confirmation number

PROVIDER PROGRAMS , BENEFIT SERVICES, BILLING SUPPORT and OUT OF COUNTRY CLAIMS

Victoria 250 952-2654

To speak to a client service representative in Provider Programs, Benefit Services, Billing Support or Out of Country Claims you will need to call long distance outside of greater Victoria. When you call please be prepared and have the following information ready as applicable:

- patients' name and PHN
- data centre/sequence number (for electronic submissions)
- date of service
- practitioner number
- payment number

OTHER SERVICE CHANGES

Elimination of MSP-assisted remittance statement reconciliation

The client service branches in MSP will no longer be able to assist physician offices with remittance statement reconciliation.

When should you call?

Our busiest telephone call days are the first four days following payment. If your questions are not urgent, you will likely find your "hold" time shorter when you contact a service representative after this time.

Physician Payment Summaries

MSP will no longer be providing physician payment summaries for income tax purposes. Physicians should be maintaining payment records for each locum service provided.

Online Claims Billing Seminars

MSP will no longer provide on-site billing seminars for medical office staff and physicians. This service has been replaced with an online self-directed learning program called MSP Tutor. This program is designed to provide you with a series of learning modules to be completed at your own pace or to use for specific fee items and topics. For further details, see "Your MSP Web Site" below or go to:

http://www.healthservices.gov.bc.ca/msp/msptutor/index.html

Keep checking for updates – new modules will be announced in the Physician's Newsletter.

TELEPLAN

The telephone numbers for the Teleplan Support line remain the same but you will be unable to transfer out from the Teleplan toll free number to other areas within MSP.

Victoria 250 952-2608
Toll-free 1 800 663-7206

YOUR MSP WEB SITE

http://www.healthservices.gov.bc.ca/msp/index.html

MSP is constantly adding features and services to make this site interesting and convenient for physicians and their office staff.

Some of the features of the site you may find useful include:

MSP Forms for Medical and Health Care Practitioners

Includes application forms for: registration, MSP billing number, Teleplan service, direct bank payment, assignment of payment, and insured out of country medical services. Forms can be downloaded and printed for completion and mailing. No need to fax or phone in your request for forms anymore!

Billing Procedures for Physicians

From here you can view and print sections of the MSP Resource Manual for Physicians, including billing procedures for General Practice and Specialty services.

Protocols and Guidelines

From this site you can view and print a complete listing of available protocols and guidelines. You will also find a list of guidelines under development, patient information guides and the process for guideline development.

MSC Payment Schedule

The complete MSC Payment Schedule is online and includes a search function for finding items by numerical fee code or text. Try it out!

Physician's Newsletter

Misplaced your recent or past issue(s) of the Physician's Newsletter? No problem! The past three issues of the newsletter are online. All you need is Acrobat Reader – a free downloadable program from Adobe. Simply click on the yellow Adobe Acrobat icon found in our web site and you are home free!

Diagnostic Code Descriptions (ICD9's)

MSP's Index and Guide to 3-Digit and 4-Digit Diagnostic Code descriptions are listed by section – the site includes an Index and additional codes that are used by MSP only.

MSC Financial Statement (Bluebook)

The MSC Financial Statement for the fiscal year ended March 31, 2001 is now posted through our MSP Publications page (http://www.healthservices.gov.bc.ca/msp/publications.html). Two versions are available, one is easy to search, the other is an Adobe Acrobat PDF version that will print out exactly like the publication. It doesn't get any easier!

MSP Fee-for-Service Payment Statistics

Each year MSP produces three booklets that provide practitioner and subscriber fee-for-service based statistics for the current year. You can find these documents by going to our "Facts and Statistics" page (http://www.healthservices.gov.bc.ca/msp/facstat.html).

MSP Tutor

MSPTutor is a series of on-line self-directed learning modules for physicians and medical office assistants (MOA's). This exciting new MSP service is available on the MSP web site at http://www.healthservices.gov.bc.ca/msp/msptutor/index.html.

MSP Tutor is designed to help medical offices understand and follow MSP claims billing procedures and rules so that their claims will be processed as accurately and quickly as possible. This easy-to-use tutorial package is broken up into short modules that focus on specific billing rules. Each module includes a short quiz that enables users to test their knowledge on a specific topic.

MSP Tutor is featured in a site specific to medical practitioners where the MSC Payment Schedule, parts of the Physician's Resource Manual, and the MSP Physician's Newsletter can be found.

A total of 18 modules are now available, including 9 modules covering Out of Office Hours Services Charges.

For information on MSP Tutor please contact: dianne.kirkpatrick@moh.hnet.bc.ca or telephone 250 952 1059.

NEW!

Web Access "Check Eligibility"

The Teleplan Web Access "Check Eligibility" function provides the same functionality as the Claims Interactive Voice Response (IVR) system, the Teleplan batch eligibility and Teleplan online eligibility function (available through the SIMPC Teleplan software). This web transaction is a new resource for eligibility checking and provides an instant response.

Eligibility Use this "Check Eligibility" function to verify if a person is eligible to have their claim for a health service paid by the Medical Services Plan. "Check Eligibility" returns a YES or NO answer for the PHN submitted.

If the response is YES, the person is eligible to have their claim for that date of service paid by MSP. If the response is NO, the screen will display additional information about why the coverage was terminated and instructions that should be provided to the patient.

If the patient is subject to alternate billing (RCMP or Armed Forces), this information will also be displayed.

Patient Status As well as checking eligibility, you can use this transaction to submit one or more specific patient status requests.

If you select "subsidy insured service" the screen will display whether MSP pays for Subsidy Insured Services for this PHN (up to a limit), or whether the patient must pay it. This information will be of interest to supplementary benefit providers.

If you select "last eye exam" this screen will return the day of the last paid eye examination for the PHN within the past 24 months. This information will be of interest to those performing eye exams.

If you select "patient restriction" and the patient has been restricted to a single general practitioner, this transaction will advise you to review the MSP Bulletin.

Note: These Patient Status answers are only returned if the person is eligible (i.e. a "YES" eligibility response, as described above). The "YES" or "NO" eligibility response is returned for all successfully completed transactions, even if no specific "Patient Status Requests" are made.

In addition, if MSP has recently issued a duplicate or replacement CareCard to the patient, the Check Eligibility response will notify you of this.

Input Fields To obtain a response to the Check Eligibility request, the following input fields must be completed:

Personal Health Number:
Enter the patient's 10 digit Personal Health Number. PHN is a mandatory field. If you leave it blank or enter invalid characters, an error message will be displayed in the message box on the input screen.

Birthdate:
Enter the patient's date of birth. All three fields within Date of Birth are mandatory. If you leave any of them blank or enter invalid dates or characters, an edit error message box will be displayed on the input screen.

Date of Service:
The Date of Service on the screen defaults to today's date. The year (CCYY), month (MM), and day (DD) can be overridden by typing new values in the fields.

Note: If you override the default date of service with another date, it cannot be greater than today's date (in the future), or more than six (6) months in the past.

Patient Status Requests for patient status information are optional. You can select none, one, or all of the check boxes for each patient PHN submitted.

Note: MSP will no longer be verifying payment of claims – it will be necessary for you to reconcile your own records.

If you are interested in accessing the new Web Access "Check Eligibility", please contact MSP: 1 800 663-7206, or Victoria 250 952-2608.

BILLING TIPS

Fee item 01011

MSP will be automating payment for the following two items, effective May 1, 2002:

01011 Patient controlled analgesia (PCA) – first day only (to include set up)
01012 Hospital visit for supervision of patient controlled analgesia during second and subsequent days, to a maximum of 2 visits per day – per visit

Notes:
a) Where more than 2 visits per day are necessary, an explanatory note in the claim note record is required.
b) 01012 is not payable on the same day as 01011.

Fee item 01011 is not payable more than once per hospitalization. Claims for supervision of PCA after the first day must be billed under fee item 01012. Claims for fee item 01011 on second and subsequent days will be refused.

Critical Care Fees

MSP will be automating payment for adult, paediatric, and neonatal critical care fees in the near future. To avoid delays in payment of your accounts, when a patient receiving critical care in one hospital is transferred to another hospital, where they continue to receive critical care, please include this information in your note record (i.e. "Transferred from hospital "a" to hospital "b").

Diagnostic Facility Services Rendered in Hospital

Hospitals are reminded that diagnostic facility services rendered to emergency, day care surgery or inpatients may not be billed to MSP, as these services are included in the hospital's global budget.

Nipple Areolar Tattooing

Nipple/areolar tattooing is included in fee item 06157 (nipple-areolar reconstruction) when done at the same sitting. Repeat nipple/areolar tattooing for fading is not a benefit when performed subsequent to the original procedure.

Meniscal Allograft Transplant

Meniscal allograft transplant is a new procedure, which is indicated for young patients who have had complete meniscetomies and are symptomatic with pain in the area where the previous procedure was performed. The BCMA Tariff Committee and the Section have been asked for their recommendations. Until a decision is reached, payment will be made in equity with fee item 50000 in the amount of $596.41.

Metacarpal Fracture

An open reduction of a metacarpal fracture should be billed under fee item 06223 at 150%. This surgical procedure is not billed under fee item 06226. The latter is intended for other than distal phalanges, which includes the medial and proximal phalanges, but not the metacarpals. This is accordance with the payment Schedule Preamble, Section B.10, c.

BILLING FOR HOSPITAL STAYS OVER 30 DAYS

The following information will clarify how to bill for visits to patients who are in hospital for over thirty days.

In accordance with Preamble B.4.3.(v) of the Medical Services Commission Payment Schedule, payment for visits to patients hospitalized over thirty days are limited to two visits per patient per week unless the following conditions are met:

- Acute intercurrent illness or
- Exacerbation of original illness requiring a greater frequency of subsequent hospital visits.

The Medical Services Plan (MSP) interprets this Preamble clause to mean that, not only must the patient be seriously ill, but there must also be a new illness or a significant worsening of an existing illness that requires active management to warrant a charge for additional visits. This information must be clearly stated in the note record submitted with your claim(s), and if requested, must be supported by the clinical record. Claims for more than two visits per week after 30 days in hospital will be given independent consideration, and will be adjudicated according to the medical information provided. Consideration will also be given for patients whose condition requires frequent monitoring and adjustment of medication on a daily basis when this information is provided in your note record.

EMERGENCY CONTRACEPTION PILL

An information sheet on the emergency contraception pill (ECP) is now available from the Ministry of Health Services' online Health Files series. The ECP Health File explains how the ECP works and where to obtain it. Health Files are written in plain English for the information of health care consumers. Please find the information sheet at the following address:

http://www.healthservices.gov.bc.ca/hlthfile/hfile38e.html

Workers' Compensation Board (WCB) News

Billing for copies of patient records provided to WCB (per the agreement between WCB and the BCMA)

The following fee items can be used to bill for copies of patient records provided to WCB. These items can and should be billed electronically through the MSP Teleplan system:

Bill fee items 19904 ($22.36) for the first 5 pages and 19906 ($1.05) for each page over 5 if the requested existing reports or chart notes do not require editing.

Bill fee item 19953 ($78.68) if existing reports or chart notes require physician review and editing in order to remove personal material not relevant to the claim. Fee item 19953 may not be billed with either 19904 or 19906.

If you have questions about these fee items, please contact WCB Health Care Services at 604 276-3085 (1 888 422-2228) or the WCB's Manager of Provider Support, Keith Whitmore at 604 279-8155 (email kwhitmo1@wcb.bc.ca).

Explanatory Codes

BF	*Claim is held for future processing*
U4	*Routine eye examinations are not a benefit of MSP*
U5	*Insufficient medical necessity provided for a repeat eye examination for the diagnosis indicated*

Change to MSP Telephone Service for the Public Effective March 4, 2002

As of March 4, 2002, toll-free telephone access for B.C. residents will be restricted to an automated information service.

The automated, toll-free service is available 24 hours a day, 7 days-a-week. Clients are encouraged to use this service during evenings and on weekends when access is most readily available.

The number to call is:

Vancouver	604 683-7151
Victoria	250 382-8406
Other Areas Within B.C.	1 800 663-7100

For beneficiaries who wish to speak directly with a client service representative, the number is 250 386-7171. Long distance charges apply to calls placed from outside the Greater Victoria area.

PATIENT INFORMATION LINE

The MSP patient information line is getting a new name – the Practitioner Information Line. Our goal is to provide toll free access to all automated services. Effective March 18, 2002 the following services will be available through this line:

- Patient coverage
  - confirmation of eligibility for supplementary benefits
  - patient surname and initials
  - date of patient's last eye exam
  - confirmation of coverage
- Confirmation of locum assignment
- Access to the Info-by-Fax system

Further automated services will be added as they become available.
Practitioner Information Line:

Victoria	250 387-1226
Vancouver	604 669-6667
Rest of BC	1 800 742-6165

RECENTLY PUBLISHED GUIDELINES (2001– 2002)

The following guidelines have been published recently by the Guidelines and Protocols Advisory Committee. They have been adopted by the Medical Services Commission and may be found on the web at www.healthservices.gov.bc.ca/msp/protoguides

- Treatment of Cataract in Adults, Revised 2000
- Antinuclear Antibody (ANA) Testing for Connect Tissue Disease
- Treatment of Gallstones in Adults, Revised 2001
- Investigation and Management of Iron Overload
- Detection of Drugs of Abuse in Urine: Methadone Maintenance Program
- Use of Hematology Profile in Adults
- Clinical Approach to Adult Patients with Gastro-esophageal Reflux Disease, Revised 2001
- Clinical Approach to Adult Patients with Dyspepsia, Revised 2001
- Follow-up of Patients After Curative Resection of Colorectal Cancer, Revised 2002
- Diabetes Care
- Clinical Management of Chronic Hepatitis B
- Clinical Management of Chronic Hepatitis C

LIST OF INSERTS

- Update to the MSC Payment Schedule
- Special Authority (SA) Categories – Quick Reference Chart
- Changes to Eye Examination Benefits
- Pharmacare Update

TELEPLAN

Invitation to Participate!

UPGRADE INFORMATION

Since November 2001, approximately 50 billing sites and 15 vendors have been participating in a pilot to use the new Teleplan v4.0 web application to submit claims and retrieve remittances over a secure Internet connection.

This pilot has been very successful – we've received positive feedback from pilot participants about the speed and ease of use of the Teleplan web application. MSP is now pleased to announce an open call for participation to all billing sites!

Some of the features of the Teleplan v4.0 web application include:

- A web-based product with a graphic user interface.
- Instant online patient eligibility checks.
- Claims submission and retrieval over an encrypted Internet connection.
- Support for high-speed internet access.
  If you have a high-speed (e.g. cable, ADSL) account or dial-up account with a local Internet Service Provider (ISP), you may use that account, or MSP will provide a SPAN/Dial dial-up account connection at no cost.
- No need for "DOS-modem"
  If you are considering upgrading your office computer, there is no longer a limitation on the type of modem required to use the Teleplan application. You may use any computer or modem, that allows you to successfully connect to the Internet.
- No additional software to install on your office computers.
  Although you still need the billing software provided by your vendor to use Teleplan v4.0, the only additional software you require is a web browser such as Internet Explorer (IE), or Netscape. The SIMPC product is no longer required.

MSP has also worked with vendors wanting to integrate the Teleplan Upgrade with their billing software. Approximately 15 vendors are now testing their implementation of Teleplan v4.0 with their billing applications. Your vendors have asked that you contact MSP if you have questions or concerns about this project.

If you are interested in trying the new Teleplan v4.0 web application,
please contact MSP
Toll free1-800-663-7206, or
Victoria 250-952-2668.

British Columbians Benefit from BC HealthGuide Program

As many as 70,000 British Columbians received assistance from the BC HealthGuide program during its first nine months of service. BC HealthGuide, launched in the spring of 2001, is designed to give individuals direct access to authoritative and reliable health information that helps them make better health care choices.

In March 2001 every B.C. household received a copy of the BC HealthGuide Handbook. Distribution of the handbook was followed with two additional components of the program – the BC HealthGuide NurseLine, a toll free call service available 24 hours a day, seven days a week; and BC HealthGuide Online, a web site resource containing thousands of pages of detailed, up-to-date, reliable information on many health topics. Translation and TTY services are additional services offered through the NurseLine service. The online service is available at www.healthguide.org.

From April 8, 2001 to December 31, 2001, there were 67,475 calls to the NurseLine. About 28% of calls were from parents on behalf of their children and 51% of calls were made by individuals for themselves. More than half (58%) of callers were female. The two most frequent categories were gastrointestinal disorders and skin problems. Sundays are the busiest days and 1700 hrs to 2200 hours is the busiest time.

Based on self-reported data, 59 callers would have called non-emergency 911 and 1269 callers would have visited the emergency room – indicating reduced pressure on these services for non-urgent health concerns. A number of callers were referred by the NurseLine to the following services: 911 (615 calls), ER (7,155 calls), and physicians (15,302). Many of these calls represent beneficiaries who may have otherwise delayed seeking timely treatment.

It is unknown exactly how many individuals avoided a visit to an ER or a physician as a result of using the BC HealthGuide Handbook or the online information resources.

To date, the overwhelming amount of feedback from both beneficiaries and health care providers has been positive, with 98% of callers expressing praise for the services they have received. The NurseLine has received numerous written and verbal compliments and only 10 complaints during this period. Complaints are thoroughly investigated to ensure approved policies and protocols were followed and appropriate action taken.

Information for family physicians and other health providers about the program is currently under development. This includes ideas for physicians on how to use the program to assist them in their practices and to benefit their patients. The B.C. HealthGuide Endorsers Council, comprised of members from the B.C. College of Family Physicians, the RNABC, the B.C. College of Pharmacists, and the Health Association of British Columbia (HABC), are assisting in the development of this part of the program.

Your feedback regarding the program is welcomed. Please send your comments and suggestions by mail to:

Integrated Health Promotion Planning,
2nd floor, 1520 Blanshard St,
Victoria BC V8W 3C8

by e-mail to:
bchealthguide@moh.hnet.bc.ca

or call:
250 952-1530 to speak with a program representative.

Paediatrician - June, 2001

An audit of a paediatrician uncovered an inappropriate pattern of billing complete examinations and prolonged counselling services. The paediatrician has agreed to make restitution of $33,000. As part of the settlement, the paediatrician has agreed to adopt an appropriate pattern of practice respecting these fee items and to bill the Medical Services Plan (MSP) only for medically necessary services actually rendered. The practitioner has also agreed to keep complete and adequate clinical records in accordance with the Medical Services Commission (MSC) Payment Schedule.

General Practitioner - August, 2001

An audit conducted on the billings of a physician determined that, in a number of instances, the notes were inadequate to support a billing of prolonged counselling to MSP. A settlement was reached and the physician has agreed to pay the MSC $18,000.

In addition, the physician has amended the style of practice and agrees to continue to remain within the average pattern of practice for prolonged counselling and, to the best of his/her ability, to maintain records sufficient to justify 00120's as defined in the MSC Payment Schedule.

General Practitioner - October, 2001

Following an audit, the MSC and a physician reached a settlement in a dispute about billings. The practitioner has agreed to make restitution of $25,500, inclusive of audit costs, relating to the fee items 0108 and 0114.

Fee item 0108 (hospital visit) was incorrectly claimed in a context where the correct fee item was 0114 (nursing home visit). Although fee items 0108 and 0114 are paid at the same rate, there are significant differences in the frequency with which they may be billed. Accounts for long-stay serious illness in acute care hospitals (0108) may be charged in full for a period up to 30 days. Care beyond this point may be charged up to two hospital visits per week when such visits are necessary. Accounts for long-term nursing-home cases (0114) may be charged up to one visit every two weeks if medically required. Non-medically required services rendered solely to meet mandatory requirements of an institution should not be billed to MSP.

General Practitioner - November, 2001

Following an audit, the MSC and a physician reached a settlement in a dispute about billings. The terms of the agreement provide that the physician will pay to the MSC the sum of $15,211, in repayment of medical services billed to MSP. The physician has also agreed to adopt an appropriate pattern of practice, and to only bill for services when the services are medically necessary, adequately documented in the patient's chart, and in conformity with the requirements set out in the MSC Payment Schedule.

General Practitioner - November, 2001

A settlement was reached in a case involving a general practitioner who was billing MSP for services that were not considered to be conventional medicine and, therefore, not benefits of MSP. The audit of the practitioner's practice also uncovered an inappropriate pattern of billing complete examinations and prolonged counselling services. The practitioner agreed to repay $20,000 for incorrect billings. The practitioner has also agreed to only bill MSP for services that are medically necessary and recognized as conventional medicine.

General Practitioner - November, 2001

The MSC has reached a settlement with a general practitioner related to a disputed pattern of billing. Through a review, the British Columbia Medical Association Patterns of Practice Committee identified an unusual pattern of billing by the practitioner and consequently referred the practitioner's billings for an audit. A number of the claims audited could not be supported by the documentation in the clinical records. The parties agreed to an estimate of $9,959 representing the sum total of the billing errors plus a portion of the audit costs.

Plastic Surgeon - December, 2001

Following an audit, the MSC and a plastic surgeon reached a settlement in a dispute about billings. The MSC alleged that the practitioner billed MSP for complex wound closures where simple wound closure procedures were appropriate. The practitioner's records did not support the billing.

The plastic surgeon has agreed to make restitution of $44,000 relating to the billing of skin graft procedures, inclusive of audit costs, and will abide by the Payment Schedule.

General Practitioner – December, 2001
A settlement was reached in a case involving a general practitioner who was billing MSP for services that were not considered to be conventional medicine and therefore not benefits of MSP. The audit of the practitioner's practice also uncovered inappropriate billings. The practitioner agreed to repay the MSC $29,350. In addition, the practitioner has agreed to only bill MSP for services that are medically necessary and recognized as conventional medicine and will maintain adequate clinical records.

Billing Errors Identified by Audit

As a result of MSP audits, there are a number of specific areas where inappropriate billing practices have been identified. The following items do not represent an exhaustive listing of the types of billing "errors" that have arisen from audits, but they do represent the most common issues that have been found. Practitioners should ensure they are aware of the billing requirements related to these issues and that their billings are in compliance with the Medical and Health Care Services Regulation and the MSC Payment Schedule in this regard.

Inappropriate Referrals

A referral is defined as a request from one practitioner that another practitioner render a service with respect to a specific patient. Such service usually would be a consultation, a laboratory procedure or other diagnostic test, or specific surgical/medical treatment.

Pursuant to section 37(1) of the Medicare Protection Act, the MSC can seek recovery from a referring practitioner for an unjustified pattern of practice with respect to referrals (e.g. not medically necessary), although the payment was made to another person, i.e., a diagnostic facility or specialist.

Assignment of Payment

Where a practitioner has assigned the right to collect fees under the Plan, the designated party may use the attending physician's practitioner number in combination with his/her own payment number when submitting claims to MSP. To authorize MSP to make payment to a designated party, the attending physician must complete and file an "Assignment of Payment" form. However, even though the payment has been assigned, the responsibility for the clinical service and its appropriate billing remains with the physician whose practitioner number is used.

Services to Family and/or Household Members

Billing to MSP for services to members of one's own family is a contravention of Section A, paragraph 19 of the MSC Payment Schedule Preamble, which relates to services to family and/or household members. It reads as follows:

1. Services are not benefits of MSP if they are provided by a medical practitioner to the following members of the medical practitioner's family:

a) a spouse,
b) a son or daughter,
c) a step-son or step-daughter,
d) a parent or step-parent,
e) a mother-in-law or a father-in-law,
f) a grandparent,
g) a grandchild,
h) a brother or sister, or
i) a spouse of a person referred to in paragraph (b) to (h).

2. Services are not benefits of MSP if they are provided by a medical practitioner to a member of the same household as the medical practitioner.

Adequate Medical Records

Since April 1, 1997 the MSC Payment Schedule Preamble has been much more specific about the requirement for adequate clinical records to justify a claim. Section B, paragraph 2 of the Preamble reads as follows:

Except for referred "diagnostic facility" services, a medical record is not considered adequate unless it contains all information which may be designated or implied in the MSC Payment Schedule for the service and unless another physician of the same specialty, who is unfamiliar with both the patient and the attending physician, would be able to readily determine the following from that record and/or the patient's medical records from previous encounters:

- Date and location of the service.
- Identification of the patient and the attending physician.
- Presenting complaint(s) and presenting symptoms and signs, including their history.
- All pertinent previous history including pertinent family history.
- The relevant results, both negative and positive, of a systematic enquiry pertinent to the patient's problem(s).
- Identification of the extent of the physical examination including pertinent positive and negative findings.
- Results of any investigations carried out during the encounter.
- Summation of the problem and plan of management.

For referred "diagnostic facility" services, an adequate medical record must include:

- Date and location of patient encounter or specimen obtained.
- Identification of the patient and the referring practitioner.
- Problem and/or diagnosis giving rise to the referral where appropriate.
- Identification of the specific services requested by the referring practitioner.
- Identification of specific services performed but not specifically requested by the referring practitioner, and identification of the physician who authorized the additional services.

Signing the Requisition

When ordering laboratory tests or diagnostic images, physicians are reminded of the importance of signing the requisition in the space provided. This is done to verify that laboratory tests are indeed ordered by a physician (dentists, podiatrists and midwives may also order certain tests - that are a benefit of MSP). When tests are ordered by telephone the laboratory is responsible for verifying and documenting in the space provided in the requisition form that the test was telephone ordered by a physician or qualified person.

BILLING FOR MULTIPLE FAMILY MEMBERS AT THE SAME VISIT

There are many legitimate reasons for more than one person in a family to attend a physician's office for medical care at the same time. In cases where each family member seen is receiving medical diagnosis and/or treatment, it is appropriate to bill for each service. However, when only one family member has a medical problem, it is almost always inappropriate to bill for discussion with other family members about that patient's condition.

For example, if a parent and child are both seen for diagnosis and treatment of upper respiratory infection during the same visit, a visit fee may be billed for each patient. If, however the child is seen for upper respiratory infection and the physician takes the history from the parent and gives treatment instructions to the parent, a visit fee may only be billed for the child. Standard medical care of a patient may require that the physician communicate with a parent, spouse, or caregiver of that patient. Such routine communication is considered to be included in the one visit fee paid for medical services to the patient, even if the communication is rendered on a different day. Please refer to Preamble, Section B.1-7 of the Medical Services Commission (MSC) Payment Schedule.

Individual counselling is the only exception in which a claim may be made in the name of a person other than the patient when the counselling is regarding that patient. As stated in the Preamble to the Medical Services Commission (MSC) Payment Schedule, "Counselling is not to be claimed for advice that is a normal component of any visit, or as a substitute for the usual patient examination fee, whether or not the visit is prolonged". In other words, time is a necessary requirement, but time is not sufficient in itself to justify billing a counselling fee. The Preamble also states: "Not only must the condition be recognized as difficult by the medical profession, but the physician's inter-vention must of necessity be over and above the advice which would normally be appropriate for that condition. Unless the patient is having significant difficulty coping,

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the counselling listing normally would not be applicable to the subsequent visits in the treatment of this disease". These statements make it very clear that billing a family member of the patient for advice regarding the patient is to be the exception not the rule. Please refer to Preamble, Section B.4.

Group counselling fees are not appropriate for advice relating to a single patient. These fees only apply when all members of the group are receiving medically required treatment or medical psychotherapy (i.e. each member of the group is a patient).

This information is provided to highlight some of the sections of the MSC Payment Schedule that deal with seeing more than one family member during the same visit, and is not expected to replace a thorough reading of the Preamble itself.

Changing Your Address?

Please notify the College of Physicians and Surgeons of British Columbia when changing your practice location. The College notifies the Medical Services Plan (MSP) monthly of physician address changes. Your registered address with the College will be used as your official registered address with the MSP.

It is important that you be aware that your address registered with MSP may be shared with our ICBC and WCB business partners. Although MSP acts as the processing agent for these agencies, occasionally they may need to contact you directly for their purposes. For this reason MSP provides them with the address registered with us.

Enrolled with MSP?

For services to be a benefit of the MSP the physician providing the service must be enrolled and in good standing with MSP. In accordance with the Medicare Protection Act, services provided by an unenrolled physician and submitted to MSP for payment under the practitioner number of an enrolled physician are not covered by MSP and are subject to recovery.

Retroactive Fee Increase April 1, 2001 to October 31, 2001

The Medical Services Commission, in accordance with Section 26(3) and Section 26(5) of the *Medicare Protection Act*, hereby amends the Payment Schedule, to provide a lump sum 6.2% increase to fees paid up to and including February 28, 2002, on all claims for services provided for the period commencing April 1, 2001 and ending October 31, 2001.

This Minute does not apply to prescribed diagnostic services, defined under Section 38(1) of the *Medical and Health Care Services Regulation*.

MSP BULLETIN

SPRING 2002

The Medical Services Plan's "Bulletin" is provided to help physicians identify patients whose MSP benefits have payment restrictions. This Bulletin provides important billing information for physicians only. Thank you for respecting the confidential nature of this information.

The Bulletin is an updated listing of restricted MSP enrollment numbers for clients who have signed a legal "Agreement of Limitation" form which limits MSP payment responsibilities to one primary care physician. If care is provided by other physicians, the charges must be made directly to the clients. MSP will not accept payment responsibility unless special circumstances are clearly stated. An example of this would be medical care that has been provided by an emergency physician in the hospital emergency room.

MSP is concerned about the potential misuse of CareCards and strongly recommends a complete check of CareCard information at all first appointments. If you suspect any unusual use of a CareCard, please request a second piece of picture identification in order to verify that the CareCard is being presented by the person named on the card.

PHN	Birthdate (MM/YY)	Sex M/F	Physician Number
9013676868	12/54	M	06541
9023967395	02/54	F	03023
9025293026	12/58	M	24287
9029287062	06/52	F	06061
9029345046	05/43	F	06541
9029596344	09/55	M	06468
9030165823	12/54	F	05334
9030205973	05/54	M	26411
9030780581	05/29	F	08241
9030861738	10/45	M	01604
9032398914	08/56	M	09760
9032842679	05/59	F	01229
9034248181	10/59	F	07384
9034793801	06/59	F	06468
9035162781	06/34	F	01454
9035294522	07/58	M	05410
9041726364	07/56	F	03733
9052634089	06/39	M	00441
9071584167	06/48	M	09604
9104870848	04/67	F	09443
9107346403	08/54	M	08365

New Guidelines Focus on Chronic Disease Management

The recent release of three new guidelines in B.C. introduces a new direction for the Guidelines and Protocols Advisory Committee. Recommending evidence-based standards of care, the guidelines for Diabetes Care, Hepatitis B and Hepatitis C emphasize the need for primary care management of these chronic illnesses through planned follow-up and patient self-management.

The care objectives in Diabetes Care are consistent with the 1998 Clinical Practice Guidelines for the Management of Diabetes in Canada, and includes a patient care flow sheet and a resource sheet for people with diabetes.

Clinical Management of Hepatitis C was distilled from a longer guideline developed by the Vancouver/Richmond Health Board. This guideline, along with Clinical Management of Hepatitis B, give indications and relative contraindications for treatment, recommending the referral of patients to physicians with expertise in hepatitis for the management of these chronic illnesses. Patient Information Guides are also included with these guidelines.

Guidelines and protocols are posted on the Medical Services Plan's web site at: www.healthservices.gov.bc.ca/msp/protoguides.

Correspondence regarding guidelines should be directed by email to:

hlth.guidelines@gems6.gov.bc.ca

or mailed to:

Guidelines and Protocols Advisory Committee
1515 Blanshard Street, 1-2
Victoria, B.C. V8W 3C8